GLOSSARY & MEDI-CAL HCO ACRONYMS

ABANDONMENT RATE – Refers to the number of incoming telephone calls placed to the Telephone Call Center from the public that are not answered by a Customer Service Representative.

ABEND – Refers to the premature ending of a program because of some kind of program or system error.

ACF/2 (ACCESS CONTROL FACILITY/2) – Computer software that protects all automated files to prevent unauthorized access.

ACS (ADDITIONAL CONTRACTUAL SERVICES) – Proposed methods of providing Contract services beyond those required in the RFP which will improve Contract administration, including methods to improve HCO performance through system improvements. ACSs offer services, functions, procedures, or processes above RFP requirements or current HCO functions.

ADA – The Americans with Disabilities Act of 1990 guarantees qualified individuals with disabilities equal opportunity in public accommodations, employment, transportation, State and local government services, and telecommunications.

ADDENDUM, CONTRACT – An addition or change made to the Contract before the Contract is signed into effect. The HCO Contract will include addenda added to the RFP.

AD HOC REPORT – A report or reports to be provided to the State by the Contractor upon a request by the State.

ADMINISTRATIVE BULLETIN – Bulletins released to potential bidders to answer questions that clarify RFP provisions.

AID CODE – An alphanumeric code defined by the State that determines the type(s) of aid a beneficiary(ies) is eligible to receive.

AIIM – The Association for Information and Image Management which is the international authority on Enterprise Content Management (ECM) and the tools and technologies that capture, manage, store, preserve, and deliver content in support of business processes.

ANSI – The American National Standards Institute which administers and coordinates the U.S. voluntary standardization and conformity assessment system.

APPLICANT – An individual seeking public assistance (aid), including persons being added to an existing eligibility case file, and any other individual(s) whose income

and/or resources are considered in determining the amount of benefit that a person(s) is due. This term is used interchangeably with “beneficiary.”

ASSIGNMENT – The action taken by the Contractor to automatically enroll a beneficiary into an appropriate health care plan when required under subsection 14016.5 (c) (1) of the California Welfare and Institutions Code.

ASSIGNMENT CONFIRMATION LETTER – Letter informing a beneficiary of automatic assignment to a health care plan.

ASSUMPTION OF OPERATONS – The date, October 1, 2007, on which the Contractor assumes responsibility for all activities included in the Scope of Work.

AUDIT – The examination and verification of the Contractor’s operations subject to the terms of this Contract.

BENEFICIARY – A person who has been determined eligible to receive public assistance (Medi-Cal benefits). This term is used interchangeably with “applicant” and "recipient."

BID – A document with price information submitted by a bidder after the technical proposal has been determined acceptable.

BIDDER – A firm whose proposal passes the technical evaluation and who submits a bid in response to the State’s Request for Proposal (RFP).

BOOKLETS – Informing packet materials bound into booklets that are mailed to applicants/beneficiaries, potential enrollees and interested parties.

BUSINESS DAY – A business day is the term used to define the specific day upon which a deliverable and/or activity and/or requirement is due. Business days are those days on which the State conducts regular business, which excludes weekends and State holidays.

CA-MMIS (CALIFORNIA MEDICAID MANAGEMENT INFORMATION SYSTEM) – The certified CA-MMIS developed under federal guidelines for the development and operation of California Medicaid processing and information retrieval. As a federally certified system, the CA-MMIS receives 90 percent federal funding for development and 75 percent federal funding for systems operation. The CA-MMIS processes all medical related claims excluding HCO.

CAP (CORRECTIVE ACTION PLAN) – A plan to provide a complete analysis of all problems and/or issues in which Contract requirements were not met, and identifies the actions and time frames necessary to correct the problems and/or issues.

CASE HEAD – A term to describe the Medi-Cal individual or head of household, which in the context of the mailing of informing materials, is synonymous with the terms "beneficiary" and "potential enrollee."

CASS (CODING ACCURACY SUPPORT SYSTEM) – Software designed to automatically update existing addresses.

CCS (CALIFORNIA CHILDREN'S SERVICES) – The public health program that provides specialized medical and HCO services to financially and medically eligible children, under the age of 21 years, who have certain physical limitations and chronic health conditions or diseases. The CCS program covers diagnostic, treatment, and therapy services.

CD – Compact Diskette.

CDHS (CALIFORNIA DEPARTMENT OF HEALTH SERVICES) – The single State Department responsible for the administration of the Medi-Cal, CMSP, CCS, CHDP, and GHPP programs. It also has responsibility for other health-related programs administered through the various divisions within the Department. The Department acts for the State of California as the Contract entity. Department/State actions are taken by the Contracting Officer or his/her designee. Generally, references to the State refer to the Department acting as the single State agency, but may be also include other State agencies or organizations involved in the Contract.

CHANGE ORDER – The document and/or process utilized by the State to direct the Contractor to perform work that falls outside of the fixed price or cost reimbursable scope of the Contract, which will result in an adjustment to Contractor payment. The Change Order process is described in Exhibit E, Additional Provisions. (Change Order is distinguished from a Contract Amendment in that the required changes are activities within the scope of the Contract and not fundamental changes to the nature of the Contract, and do not require Contractor approval to implement.)

CHDP (CHILDREN HEALTH AND DISABILITY PREVENTION PROGRAM) – A government-funded program that provides periodic health assessments to eligible children and youth under the age of 21. Children and youth with suspected problems are then referred for diagnosis and treatment.

CHOICE FORM – The State's form used by the beneficiary to indicate their choice of methods for receiving Medi-Cal services. The choice form is completed by the beneficiary in order to select a medical and/or a dental plan, or Fee-For-Service (FFS), where there is a FFS option.

CMMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) –The Federal government program that monitors the State health care programs.

CMSP (COUNTY MEDICAL SERVICES PROGRAM) – A public health program administered by the Department's Office of County Health Services (OCHS) to provide

medical and dental care to medically indigent adults, aged 21-64, who are of marginal income and who are not eligible for the State's Medi-Cal Program.

CN (CLOSURE NOTICE) – The final documentation step within the Problem Correction System (PCS) process to confirm that a problem identified on a Problem Statement has been corrected, and that adequate steps have been taken to prevent a reoccurrence.

COMPUTER OPERATIONS MANUAL – A manual developed and maintained by the Contractor to house detailed technical descriptions of all HPE system procedures, processes, jobs, schedules, reporting specifications, and quality control standards and methods.

CONFIDENTIAL INFORMATION – Specific facts and/or documents identified as not to be disclosed and/or are deemed private by law, regulations or Contractual language.

CONTRACT – The written agreement between the State and the Contractor.

CONTRACT EFFECTIVE DATE (CED) – The date upon which the terms of the Contract begin. The Contract effective date is specified in the Contract on the State Standard Contract form number 213.

CONTRACT REQUIREMENT – Any service, deliverable and/or other duty(ies) that the Contractor is required to provide or perform under the terms of the Contract.

CONTRACT TERMINATION DATE – The date upon which the terms of the Contract terminate. The Contract termination date is specified in the Contract on the State Standard Contract form number 213.

CONTRACTING OFFICER – Refers to the State official responsible for managing the Contract.

CONTRACTOR – The HCO enrollment broker that educates beneficiaries of their health care plan choices and processes beneficiary enrollments and disenrollments into and out of health care plans on behalf of the State.

CONTRACTOR COST – The actual expenses incurred by the Contractor to perform any task as part of this Contract. See Exhibit B for definitions of allowable costs that are considered cost reimbursement activities. Certain Contractor bid prices are required to be based upon Contractor costs.

CONTRACTOR REPRESENTATIVE – Refers to the Contractor official responsible for managing the Contractor’s operations.

COUNTY CODE – A two-digit code assigned by the State to identify each county within the State.

CRT (CATHODE-RAY TUBE) – The technology inside a traditional computer monitor.

CSRs (CUSTOMER SERVICE REPRESENTATIVES) – The Contractor's Telephone Call Center employees who provide assistance to beneficiaries, potential enrollees and interested parties via toll-free telephone lines.

CSRG (CUSTOMER SERVICE REPRESENTATIVE GROUP) – See above.

CWD (COUNTY WELFARE DEPARTMENT) – The local County Social Services Office or other County agency responsible for determining the initial and continuing eligibility of persons for the TANF (Temporary Assistance for Needy Families – formerly known as AFDC) and/or Medi-Cal programs.

DATA DICTIONARY – A database or file containing 1) database description, both schema and subschema, and 2) a system/collection of programs. Basically, it is a central storage facility for data definitions, programs/modules, documentation, and run-time information. HCO uses the cullinet support, product Integrated Data Dictionary (IDD). Refers to a collection of records, elements, sets or areas.

DATA ENTRY – Method of entering data, or information, into the HPE system from choice and request forms.

DAY – The word "day" in this Contract shall be a CALENDAR DAY unless otherwise specified (see also BUSINESS DAY).

DCN (DOCUMENT CONTROL NUMBER) – A unique number assigned to each choice and request form, which is used to identify the document throughout processing and for retrieval purposes. The number includes the Julian date of receipt by the Contractor.

DEDICATED STAFF – Staff that is solely assigned to perform work under a specified provision of this Contract. Dedicated staff shall be strictly maintained at a level no less than that required in the RFP or proposed in the technical proposal, whichever is greater, and shall be guaranteed at that level for the life of the Contract. Dedicated staff and any changes thereto, shall be identified by name, in writing, and may not be committed by the Contractor to work activities outside the areas of the Contract section designating them as dedicated staff without prior written approval of the Contracting Officer. The functions of these dedicated staff shall be adjusted based upon the work requirements of the State.

DELIVERABLE – The specific product the Contractor is required to submit upon completion of a task or subtask. When the deliverable is intangible, documentation must be provided demonstrating completion.

DEPARTMENT/STATE – Refers to the California Department of Health Services (CDHS) and/or other California State agencies or organizations.

DHHS (DEPARTMENT OF HEALTH AND HUMAN SERVICES) – The federal agency responsible for the management of the Medicaid Program.

DISENROLLMENT – A transaction by which a beneficiary is disenrolled from a managed care plan which is received by the HPE system and applied to MEDS.

DISPUTE – A controversy arising under this Contract between the State and the Contractor regarding the Contracting Officer's determinations concerning the terms and conditions and/or Contractual obligations embodied in this Contract. Further details on disputes and dispute resolution are provided within Exhibit E, Additional Provisions of this RFP.

DOWNTIME – The period of time that the HPE system is not available or "inhibited" to a State user or a State user terminal.

DPD (DETAILED PROGRAM DESIGN) – A document the Contractor shall ensure exists for all HPE system programs. A DPD shall consist of a specified pictorial diagram along with a brief narrative describing the major functions performed.

DPS (DETAILED PROGRAM SPECIFICATIONS) – A detailed program description for each major program paragraph in the HPE system.

DPSS – County Department of Public Social Services.

EDI – Electronic Data Interchange.

EDIT – An examination in the claims processing subsystem of data on a document performed to ensure application of program policy. Edits include examination for such things as completeness and validity of data, recipient and provider eligibility, and necessity for manual pricing and HCO consultant review.

EMERGENCY DISENROLLMENT ENROLLMENT REQUEST (EDER)– An emergency disenrollment of a beneficiary from a health care plan based upon specified reasons, such as, the beneficiary requires specialized services for a complex medical condition, or other medical situations for which a delay could adversely impact the health of the beneficiary.

ENHANCEMENT – A new feature or modification of an existing feature requiring a change to the automated or manual portion of the HCO system and/or process.

ENROLLMENT – The process by which an eligible beneficiary becomes a member of a health care plan.

ENROLLMENT BROKER – The Contractor awarded the Contract to provide Medi-Cal managed care education and enrollment services to potential enrollees, beneficiaries and interested parties for the State.

ESCROW BID DOCUMENTS – All documentary information developed by the bidder in preparation of bid prices for this RFP. Escrow bid documents for the successful bidder/Contractor are typically held in escrow for the duration of the Contract.

ESRs (ENROLLMENT SERVICE RESPRESENTATIVES) – The Contractor's employees who are stationed in the various HCO counties throughout California that provide face-to-face assistance to potential enrollees, beneficiaries and interested parties for the State.

EXTERNAL REPORTS – Any reports that are designed, developed and implemented by the Contractor to be shared with outside interested parties, including the State.

FACILITIES – The physical building site(s) used by the Contractor to perform HCO operations.

FBU (FAMILY BUDGET UNIT) – The total number of beneficiaries combined in one eligibility case.

FFP (FEDERAL FINANCIAL PARTICIPATION) – That portion of Medi-Cal funding provided by the federal government. The FFP must be matched by a varying percentage of State funds.

FFS (FEE-FOR-SERVICE) – The reimbursement provided to medical and dental providers for actual services rendered to Medi-Cal beneficiaries.

FILE – Used to describe:1) A collection of many occurrences of the same type of records, commonly referred to as a data set. Entity type that refers to magnetic tape, cartridges, disk storage both sequential and direct access, and other non- database files; and 2) A logical unit of database storage.

FIPS (FEDERAL INFORMATION PROCESSING STANDARDS) –

FISCAL YEAR (FY) – Any 12-month period for which annual accounts are kept. The State fiscal year is July 1 through June 30; the federal fiscal year is October 1 through September 30.

FIXED COST – Costs which do not change with fluctuations in enrollment, in utilization of service, or in Medi-Cal billings.

FPC – Forms Processing Clerk.

FULFILLMENT – All activities required to produce, process and distribute all informing materials.

GENERAL TERMS AND CONDITIONS – Specifies the terms and requirements of the Contract applicable throughout the life of the Contract.

GFR (GENERAL FUNCTIONAL REQUIRMENTS) PHASE – The GFR is a phase that includes a general description of the various objectives of the change/modification and the general and specific desired results/solution.

GMC (GEOGRAPHIC MANAGED CARE) – Counties within the managed care program with more than two health plans available among which beneficiaries and/or potential enrollees may choose.

GSD (GENERAL SYSTEM DESIGN) – A document provided by the Contractor consisting of a series of schematics depicting the overall operational processes and system flows with each diagram accompanied by a narrative that describes each system task, including all related inputs and outputs.

GUI (GRAPHICAL USER INTERFACE) – A type of display format that enables users to choose commands, start programs, and see lists of files and other options by pointing to pictorial representations (icons) and lists of menu items on the screen. The Contract requires the Contractor to ensure that user sessions make full use of the current PC workstation GUI.

HCO (HEALTH CARE OPTIONS) PROGRAM – The State program whereby Medi-Cal applicants/beneficiaries and potential enrollees are provided assistance in making informed health care plan decisions.

HCO CONTRACT LETTER (C Letter) – The letter that provides directions and/or instructions to the Contractor regarding approvals, policies, procedures and/or other changes to the HCO Program.

HCO PROGRAM RECORDS – As used in this Contract, include but are not limited to, all correspondence, forms or reports (hard-copy or electronic format) that are part of, produced from, or generated as a result of HCO Program activities.

HCP (HEALTH CARE PLAN) – A Medi-Cal managed care plan contracted with the State to provide Medi-Cal beneficiaries health care services under Chapter 7 or Chapter 8 of Division 9, Part 3 of the California Welfare and Institutions Code.

HHSDC (HEALTH AND HUMAN SERVICES DATA CENTER) – A California State agency created to provide customers with IT (Information Technology) leadership, services and a technical infrastructure that allows them to deliver quality program services.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) – The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191, was enacted on August 21, 1996. HIPAA amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 (Code) to provide for, among other things, improved continuity

(also called “portability”) and availability with respect to group health plan coverage and group health insurance provided in connection with employment, and insurance coverage in the individual insurance market (not connected with employment).

HMO (HEALTH MAINTENANCE ORGANIZATION) – The term Health Maintenance Organization is specifically defined in the Health Maintenance Act of 1973 (Public Law 93-222) as a legal entity or organized system of health care that provides directly or arranges for a comprehensive range of basic and supplemental health care services to a voluntarily enrolled population in a geographic area on a primarily prepaid and fixed period basis. The term is sometimes used loosely to denote any organized prepaid system; however, there are formal federal qualifications procedures for official HMOs.

HOLD STATUS – A status into which an enrollee is placed by county social services agencies while continuing eligibility for Medi-Cal is being assessed. Capitation to the health plans is not paid during this time period.

HPD –

HPE SYSTEM – The Health Plan Enrollment System used to process transactions for the Health Care Options Program.

INFORMING MATERIALS – Informational materials provided to applicants/ beneficiaries and potential enrollees to assist them in making an informed choice of a health plan.

INFORMING PACKET – An envelope containing informing materials mailed to applicants/beneficiaries, potential enrollees and interested parties.

INTENT TO ASSIGN LETTER – A letter provided to beneficiaries in their informing packets to inform them that they are required to make a choice of a managed care health plan within 30 days of receipt.

INTENT TO DEFAULT LETTER – A letter provided to beneficiaries to inform them that the State will randomly automatically assign them to a managed care health plan if they do not choose a plan themselves within 45 days of receipt of the Intent to Assign Letter.

INTERNAL REPORTS – Any reports designed, developed, and implemented by the Contractor for its use in managing its Contract with the State.

IR (INTERIM RESPONSE PS) – A category of action in which an Initial Problem Statement can transition under certain conditions as specified in the PCS process.

IVRS (INTEGRATED VOICE RESPONSE SYSTEM) – A call vectoring system that allows callers to input their MEDS identifying information before a Call Services Representative answers the call.

JACKSON v. RANK – Lawsuit filed and judgment rendered by the U.S. District Court that requires the California Department of Health Services to send notice to Medi-Cal recipients at the time of Department action on medical provider requests for prior authorization for payment for medical services.

JULIAN DATE – A calendar system in which each day of the year is assigned a corresponding number.

LETTER OF INTEREST – A letter sent to the Office of Medi-Cal Procurement by a potential proposer expressing interest in submitting a technical proposal and identifying the prime Contractor, address, liaison person(s), and any proposed subcontractor.

MAGNETIC MEDIA – A computerized form of data or information storage. Magnetic tape is an example of this form.

MAGNETIC TAPE/TAPE CARTRIDGE – All RFP reference to magnetic tape and tape cartridge shall mean tape cartridge when referring to State and Contractor data exchanges. Tape cartridges must be useable in IBM 3480 tape drives. The standard for all data exchanges between the Contractor and the State shall be tape cartridges unless the Contracting Officer approves the use of computer tapes.

MAILINGS – A term typically used to refer to the mailing of packets, postcards, letters, notices or any other type of information materials mailed to applicants/beneficiaries.

'MAKE AVAILABLE' – The requirement that materials be available to appropriate personnel during regular business hours for both announced and unannounced review.

MANAGED CARE – A planned, comprehensive approach to health care that combines clinical services and administrative procedures within a coordinated system constructed to provide cost-effective and timely access to primary care.

MANDATORY AID CODE (OR MANDATORY BENEFICIARY) – A category of aid codes in which the beneficiary is required to enroll in a managed care plan.

MCP (MANAGED CARE PLAN) – A health care plan that Contracts with an organized provider network which delivers quality services in a cost-effective manner.

MEDICAID – The federal medical assistance program enacted by the 1965 Title IX amendments to the Social Security Act.

MEDI-CAL – In California, the Title XIX Federal Medical Assistance Program (Medicaid) intended to provide federal and State financial assistance for medical and dental care of needy persons meeting program eligibility standards.

MEDI-CAL MANAGED CARE OMBUDSMAN – The unit within the State Medi-Cal Managed Care program assigned as liaison between the health plans and enrollees.

MEDI-CAL POLICY – Medi-Cal policy is defined in a number of documents including California Statues, Title 22, California Code of Regulations. HCO Operating Instruction Letters, Medi-Cal HCO Provider Bulletins, adopted change orders, the California Standard Nomenclature, the HCO Criteria Manual, Suspense and Error Handling Manual, Professional/Paraprofessional Adjudication Manual, the Requirements Definition Manuals and other HCO manuals.

MEDICARE – The federally financed program under Title XVIII of the Social Security Act, which provides health insurance primarily for the aged, 65 and over. It also covers persons eligible for Social Security Disability payments and for certain individuals who need kidney dialysis or transplantation.

PART A: Hospital Insurance Program - The compulsory portion of Medicare which automatically enrolls all persons aged 65 and over, those entitled to benefits under OASDI or railroad retirement, persons under 65 who have been eligible for disability for over two years, and insured workers (and their dependents) requiring renal dialysis or kidney transplantation. The program pays after various cost-sharing requirements are met, for inpatient hospital care and care in skilled nursing facilities and home health agencies following a period of hospitalization. The program is financed from a separate trust fund funded with a contributory payroll tax levied on employers, employees and the self-employed.

PART B: Supplementary Medical Insurance Program - The voluntary portion of Medicare in which eligible persons may be entitled to the services listed below. The program is financed from monthly premiums paid by persons insured under the program and a matching amount from federal general revenues. About 95% of eligible people are enrolled. During any calendar year, the program will pay (with certain exceptions), 80% of the reasonable charges (as determined by the program) for all covered services, after the insured pays deductible on the cost of such services. Covered services include physician services, home health care, medical and other health services, outpatient hospital services, and laboratory, pathology and radiology services. Any individual over 65 may elect to enroll in Part B. Medi-Cal buys in Part B coverage for elderly, blind, and disabled public assistance recipients, pays the premium, deductibles and coinsurance on their behalf. The Medi-Cal program Contracts with carriers to process claims under the program. The carriers determine amounts to be paid for claims based on reasonable charges.

MEDS (MEDI-CAL ELIGIBILITY DATA SYSTEM) – The automated eligibility information processing system operated by the State which provides on-line access to counties for recipient information, updates of recipient eligibility data and on-line printing of immediate-need Medi-Cal cards. The MEDS also produces regular Medi-Cal cards and maintains data on federal SSI/SSP - Medi-Cal buy-in beneficiaries.

MILESTONE – A reference point marking a major event in a project and used to monitor the project's progress.

MMCD – Medi-Cal Managed Care Division.

MN (MEDICALLY NEEDY) – Persons who are determined to have met the eligibility criteria for cash welfare assistance in that they are aged, blind, disabled, or TANF-linked (formerly known as AFDC). However, they are disqualified for cash assistance because they refuse it, have excess earnings, income, or hours of employment, or are in long-term care facilities. Some MNs have to share in the cost of their medical care.

MOE (MONTH OF ELIGIBILITY) – The date that an enrollee is eligible for Medi-Cal assistance.

MOU (MEMORANDUM OF UNDERSTANDING) – An MOU is used in conjunction with the Master Contract Agreement and usually contains routine contract provisions unique to the Contract but is not used to encumber funds.

MQAPR – Monthly Quality Assurance Performance Report.

NON-COMPLIANT BEHAVIOR – (see Precedent to Payment).

NON-MEDS PROCESS – The 120-day verification process which occurs when an enrollment form is received by the Contractor prior to eligibility for the beneficiary being established in the MEDS system. An eligibility status check occurs daily for up to 120 business days. If the status changes to an eligible aid code, the enrollment form is processed as usual and no informing packet is sent to the beneficiary and no default occurs. If *no eligibility* is established during the 120 business days, the form is considered to be invalid but the information is stored in the history file for future reference. If the beneficiary's eligibility is established after the 120 business days, the beneficiary is considered a new eligible with no form on file and is sent an informing packet and placed on the default path.

NOTICE OF INTENT TO AWARD – The date on which the State provides public notification of the successful bidder of this RFP and its intent to award the Contract to such bidder.

OCR – Optical Character Reader.

ONLINE DISENROLLMENT – Disenrollment transactions submitted via the MEDS online transaction process.

ONLINE ENROLLMENT – Enrollment transactions submitted via the MEDS online transaction process.

OPERATIONS – The routine activities undertaken in fulfillment of the terms of this Contract. The areas of operation include Systems (transactions, etc.), Mailhouse, Call Center, Field Operations, Research, Quality Assurance, etc**.**

OS – Operating System.

PCP (PRIMARY CARE PROVIDER) – A person responsible for supervising, coordinating and providing initial and primary care to beneficiaries, initiating referrals and for maintaining the continuity of patient care. A primary care provider may be a primary care physician or non-physician medical practitioner.

PCS (PROBLEM CORRECTION SYSTEM) – A system that receives, processes, tracks, and reports on all problem statements issued by the State and/or Contractor.

PDA – (systems section)

PHI (PROTECTED HEALTH INFORMATION) – Confidential information as defined by the regulations implementing HIPPA (Health Insurance Portability and Accountability Act (45 CFR 160 et seq.)). PHI consists of any health-related information associated with an identified person, or with information that can be used to identify a person.

PHP (PREPAID HEALTH PLAN) – An organized system of health care which guarantees to provide one or more medical services for a voluntary enrolled group of people for a fixed prepaid period of payment. This term describes some programs that Contract with the Department to provide services to Medi-Cal recipients on a prepaid basis. PHPs are roughly synonymous with “Health Maintenance Organizations.”

PHP TABLE (PREPAID HEALTH PLAN MONTHLY PROJECT CONTROL TABLE) – The PHP table specifies the aid and zip codes served by a health plan.

PID – Plan-initiated disenrollments.

PILOT PROGRAM – A tentative program for future development.

PMIF – Pooled Money Investment Fund.

POTENTIAL ENROLLEE –

PRECEDENT TO PAYMENT – This RFP contains payment provisions wherein certain conditions precedent to Contractor payment require the receipt of specific goods or services before release of payment.

PRICE PROPOSAL – A proposer response that presents a complete description of the proposer’s cost of specific operation areas of the RFP.

PROFESSIONAL REVIEW ORGANIZATION – A federally funded organization charged with comprehensive and ongoing quality review of services provided under the Medicare and Medicaid Programs.

PROPOSER – A firm that submits or plans to submit a technical proposal in response to this RFP.

PROVIDER – An individual or organization enrolled by the Medi-Cal HCO program to provide services to Medi-Cal beneficiaries. In this Contract, the Contractor performs the Provider Enrollment functions in accordance with State policy and directions.

PROVIDER MANUALS, BULLETINS – Provider manuals contain information to providers regarding Medi-Cal HCO Program procedures, policies, statutes and regulations. The provider manual is updated by bulletins that replace outdated pages with current Medi-Cal information.

PROVIDER MASTER FILE (PMF) – The file (database) which contains a record for each provider or doctor's group certified to provide services under the Medi-Cal program. The file also includes rendering providers, providers who are suspended from participation in the program, and those placed on special prepayment review, including special prior authorization review. The file is used in the daily payment of provider claims and for accomplishing various MARs and S/URs reporting.

PS (PROBLEM STATEMENT) – A standard, State-approved Problem Statement form for use by the State and Contractor staff, as well as other interested parties designated by the State, to describe the root causes of the PS, and to specify the measures that are being taken to correct it and to prevent a recurrence.

QA – Quality Assurance.

QASPM – Quality Assurance Standards and Procedures Manual.

QMS – Quality Management System.

QUALITY MANAGEMENT UNIT – A unit consisting of Contractor employees who coordinate and conduct quality management activities for Contractor staff. Staff within this unit provides reactive measurement and reporting of system performance and proactive policy review and recommendations.

RACF (RESOURCE ACCESS CONTROL FACILITY) – Computer software that protects all automatic files to prevent unauthorized access.

RECIPIENT – A person enrolled in and eligible for benefits under the Medi-Cal program.

REDETERMINATION – The annual re-determination of a Medi-Cal beneficiary's continued eligibility to receive public assistance and/or Medi-Cal benefits.

RENOTIFICATION – An annual notice sent to health plan enrollees informing them of the availability of other health plans in their county and the enrollee's option to change their health plan.

REQUIREMENT, CONTRACT REQUIREMENT – Any service, deliverable, or other duty which the Contractor is required to provide or perform under the Contract.

RETROACTIVE DISENROLLMENT – A request by a health plan for disenrollment of a beneficiary for the prior month, usually due to a beneficiary already receiving care from another provider for immediate care needs.

RFP (REQUEST FOR PROPOSAL) – The document that describes to prospective proposers the requirements of the fiscal intermediary system, terms and conditions of the Contract, and technical information.

RFP SECTION – This title refers to the entire language in each major portion of the RFP beginning with the same whole Attachment and Section reference within the appropriate Exhibit. If in the body of the RFP, the word section is followed by a more detailed reference, the definitions in the body of the RFP shall be used.

RIC (REQUEST FOR INFORMATION/CLARIFICATION) – A request by county social services agencies to an enrollee for information/clarification to determine new or continuing eligibility status.

RISK ANALYSIS – All risks associated with collection, storage, processing, transition, transportation, discarding, or any other use of data.

RRPR (RECORDS RETRIEVAL PERFORMANCE REPORT) – A monthly report produced and provided by the Contractor to the State each month to include specified information related to records requests as outlined in Exhibit A, Attachment II, Section H, Records Retention and Retrieval.

RRRP (RECORDS RETENTION AND RETRIEVAL POLICY) – A manual developed, implemented and maintained by the Contractor that shall govern both the Contractor and the State. The RRRP manual shall describe the specific steps the Contractor must follow to achieve full compliance with records retention and retrieval requirements as established in this RFP.

RUM (REPORTS USER MANUAL) –

SDN (SYSTEM DEVELOPMENT NOTICE) – The State generated document utilized to notify the Contractor of system changes that require programming alternations and development activities to be performed by the Contractor's SG.

SFD (SPECIFIC FUNCTIONAL DESIGN) – A deliverable provided by the Contractor to the State in which the Contractor shall describe the design approach the Contractor's technical staff will use to produce programming specifications.

SG (SYSTEMS GROUP) – Contractor employees who design, develop, install, modify and maintain the HPE and supporting systems for the HCO Program. In addition, the SG is dedicated to processing erroneous payment corrections, performing emergency program maintenance, and activities necessary for final resolutions to problem statements that require programming changes to the HCO Program.

SPDs – Refers to the term Seniors and Persons with Disabilities (also known as aged, blind and disabled).

SSI/SSP (SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTAL PAYMENT) – The eligibility program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons (also known as SPDs).

SSR (SYSTEM SERVICE REQUEST) – A document used to request and document the need for minor corrections/modifications to processes, reports, screens, tables, etc.

STATE – The State of California: The State acts through the California Department of Health Services (CDHS) with the Department as the Contract entity. State/Department actions referenced in this Contract, such as Know-Keene licensure and various audits are performed by other State agencies and/or taken by the Contracting Officer or their designee.

STATE WORKDAY – (See Business Day.).

SUBCONTRACTOR – An agreement entered into by the Contractor with any other organizations or person(s) who agree to perform an administrative function or service of the Contractor specifically related to securing or fulfilling the Contractor's obligation to the Department under the terms of this Contract.

SVR (SYSTEM VARIANCE REQUEST) – The document used by the State to identify system problems to the fiscal intermediary during acceptance testing.

TECHNICAL PROPOSAL – A proposer's response that presents a complete description of the proposer's plans to meet the requirements of specific areas of the RFP.

THRESHOLD LANGUAGES – Languages other than English that are used to inform and educate enrollees of their options within Medi-Cal. MMCD determines which languages are considered "threshold."

TITLE 22 – Title 22, Division 3, California Code of Regulations contains the rules and regulations governing the Medi-Cal program. These regulations define and clarify the provisions of State statute, primarily the Welfare and Institutions Code.

TITLE XVIII – The portion of the Social Security Act that authorizes the Medicare program.

TITLE XIX – The portion of the Social Security Act that authorizes the Medicaid program. (Medi-Cal is California's Medicaid program.)

TCC – The Contractor's Telephone Call Center that provides all functions as required by the Contract.

TCC ABANDONMENT RATE – The rate at which callers choose to disconnect from the call after hearing the IVR system greeting and spending twenty (20) seconds or more in-queue without being connected to a TCC CSR.

TCC REPORTING REQUIREMENT – As a requirement of the Contract, any unscheduled TCC downtime must be reported on a State-approved form by way of the PCS process or the Incident Reporting System.

TCC UNSCHEDULED DOWNTIME – As a requirement of the Contract, any unscheduled TCC downtime shall not exceed one-half hour per week on average for any given month.

TDD LINES (Telecommunications Device for the Deaf) – Telephone lines to provide services to hearing impaired callers.

TOLL-FREE TELEPHONE STAFF – Contractor employees whose sole purpose and work responsibilities are exclusively dedicated to telephone activities generated by beneficiary or provider inquiries/complaints, potential enrollees and interested parties.

TSD (TECHNICAL SYSTEM DESIGN) –

TURNOVER – The portion of the Contract that constitutes the work requirements associated with the transfer of the HCO Program from the current Contractor at the end of the Contract to the new Contractor.

TRANSACTION – The enrollment or disenrollment of a beneficiary(ies) into or out of a managed care plan within the HPE and MEDS systems for the Health Care Options Program.

TWP (TAKEOVER WORKPLAN) – The Contractor's detailed activities that are to be used to meet all Contract Takeover requirements.

THE UNIFIED MODELING LANGUAGE (UML) – The industry-standard language for specifying, visualizing, constructing, and documenting the artifacts of software systems. It simplifies the complex process of software design, creating a "blueprint" for construction.

VOLUNTARY AID CODE (OR VOLUNTARY BENEFICIARY) – A category of aid codes in which the beneficiary is not required to enroll in a managed care plan, but may qualify to voluntarily choose to enroll into a plan(s).

WBS (WORK BREAKDOWN STRUCTURE) – A component of the Contractor's TWP in which a code is used to identify all work performed during Takeover.

WDE (WEEKLY DELIVERABLE EXCEPTION REPORT) – A weekly report in the form of a chart that displays those deliverables, milestones, walkthroughs, and State approvals from the Weekly Deliverable Status Report that are past due.

WDSR (WEEKLY DELIVERABLE STATUS REPORT) – A weekly report in the form of a chart that includes the status of deliverables, milestones, walkthroughs and State approvals to aid the State in determining, among other things, the Contractor's progress during Takeover.

WEEKLY AVERAGE WAIT (OR HOLD TIME) – The time expired commencing from the time a caller is initially placed on hold by a TCC CSR to the time telephone assistance by a CSR to the caller is resumed. The total wait or hold time shall not exceed sixty (60) seconds.

WEIGHTING – The method for assigning a relative proportion of the technical proposal score to a proposal based on criteria deemed of importance and priority to the State. These weights multiplied by the maximum score allowed will equal the total technical score available.

W&I (WELFARE AND INSTITUTIONS CODE) – The California code of law that includes the Medi-Cal Act.

WIC (WOMEN, INFANTS, AND CHILDREN) – A State program originally designed to meet the nutritional needs of women, infants and children, but which has expanded to include education, outreach, etc.

WORKING CAPITAL – This term means current assets less current liabilities.

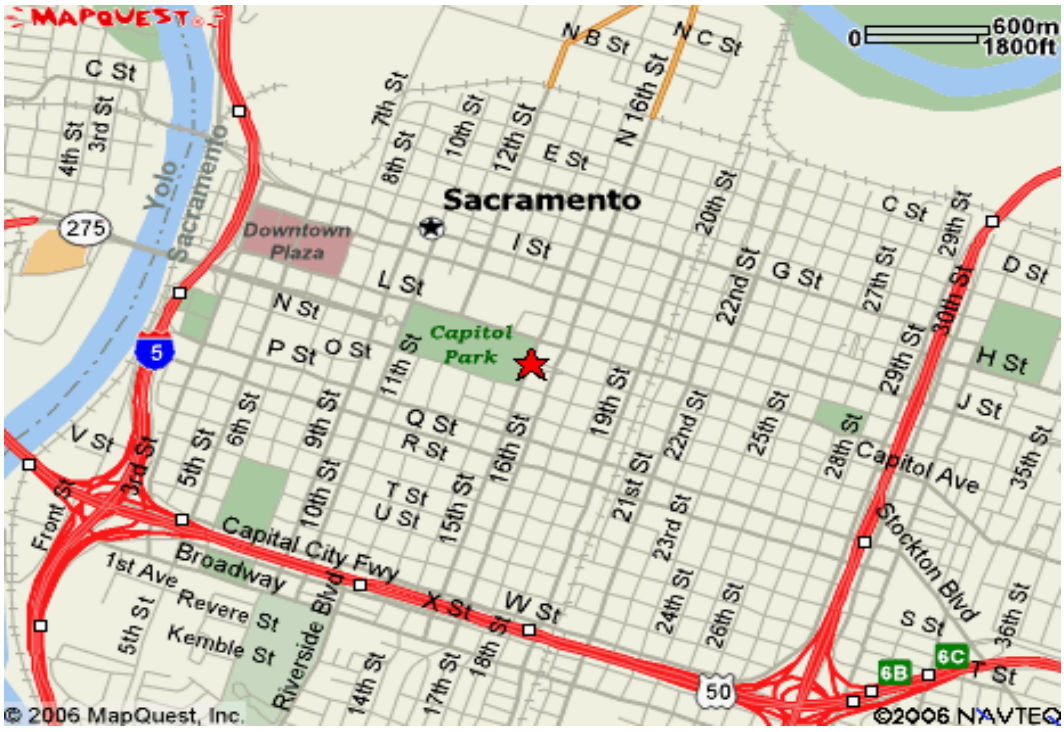
Enclosure C

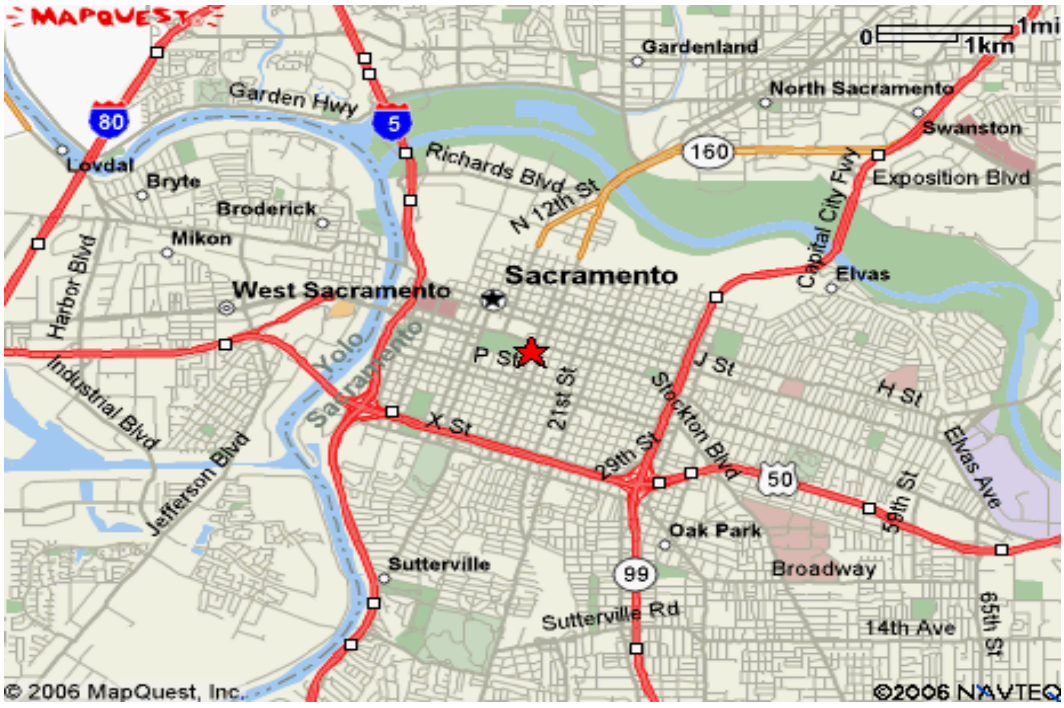
iManage Database Index			
Folder Name	**#Docs**	**CD#**	**Description**
Maximus Technical Proposal-Price Bid	3	1	
Contract Amendments	3	2	Language added to original Contract language that makes revisions, deletions and/or additions to current Scope of Work and/or other provisions of the Contract.
H Letters '01	120	3	The letter that provides directions and/or instructions to the Contractor regarding approvals, policies, procedures and/or other changes to the HCO program.
H Letters '02	365	4	
H Letters '03	549	5	
H Letters '04	449	6	
H Letters '05	447	7	
H Letters '06	447	8	
Monthly Progress Reports '01	68	9	Monthly report provided by the Contractor to the State which are a compilation of various activities and data produced and gathered throughout the month, as directed by the State.
HCO Staffing	1	10	Monthly report provided by the Contractor to the State which details the number, type of staff and the Full-Time Equivalents of each that the Contractor has devoted to the HCO Program.
Monthly Progress Reports '02	46	11	
Monthly Progress Reports '03	18	12	
Monthly Progress Reports '04	31	13	
Monthly Progress Reports '05	19	14	
Monthly Progress Reports '06	3	15	
Presentation Schedules '05-'06	30	16	A detailed list, by date, time and location, of Enrollment Service Representatives face-to-face presentations, provided to the State by the Contractor on a monthly basis.
Problem Statement Reports '01-'06	47	17	Monthly and weekly reports provided to the State by the Contractor which provide details of issues in which the Contractor does not meet contractual obligations.

iManage Database Index			
Folder Name	**#Docs**	**CD#**	**Description**
System Notices '02-'06	113	18	
Emergency Disenrollment-Med Exemption '00-'06	32	19	A monthly report provided by the Contractor to the State which details all emergency disenrollments and medical exemptions received by the Contractor and approved by the State.
Exemption Request Report '00-'06	59	20	A monthly report provided by the Contractor to the State which details all exemption to health plan enrollment requests received by the Contractor.
Accepted Exemption Reports '00-'06	67	21	A monthly report provided by the Contractor to the State which details all exemption to health plan requests that were approved by the State.
Mandatory Eligibles Report '00-'06	85	22	
Invoice Receipts '06	10	23	Written documentation from the Contractor of providing monthly invoices to the State.
Invoice Receipts '05	35	24	
Invoice Receipts '04	27	25	
Invoice Receipts '03	22	26	
Invoice Receipts '02	20	27	
Invoice Receipts '01	9	28	
Maximus Policy and Procedures		29	The Contractor's manuals which state their State-approved policy and procedures that are used to perform contractual requirements of the HCO Program.
Searches should include documents with a 5/01/01 date or newer because of the contract effective date.			

Appendix 3

Maps/Directions





Maps/Directions

	**1:**Merge onto I-5 N.	366.1 miles
	**2:**Take the J STREET exit toward DOWNTOWN.	0.2 miles
	**3:**Turn SLIGHT RIGHT onto J ST.	0.9 miles
	**4:**Turn RIGHT onto 15TH ST / CA-160 S.	0.2 miles
	**5:**Turn LEFT onto CAPITOL AVE.	<0.1 miles
	**6:** End at **1501 Capitol Ave** Sacramento, CA 95814-5005, US	

Total Est. Time: 5 hours, 47 minutes **Total Est. Distance:** 385.26 miles

From Los Angeles

Maps/Directions

	**1:** Take I-80 E toward BAY BRIDGE / OAKLAND / SEVENTH ST / US-101 N (Portions toll).	81.5 miles
	**2:** Take CAPITAL CITY FWY / US-50 E toward SACRAMENTO / SOUTH LAKE TAHOE.	4.3 miles
	**3:** Take the CA-160 / 15TH STREET exit.	0.2 miles
	**4:** Turn SLIGHT LEFT onto X ST.	<0.1 miles
	**5:** Turn LEFT onto 16TH ST / CA-160 N.	0.8 miles
	**6:** Turn LEFT onto CAPITOL AVE.	<0.1 miles
	**7:** Make a U-TURN at 15TH ST onto CAPITOL AVE.	<0.1 miles
	**8:** End at **1501 Capitol Ave** Sacramento, CA 95814-5005, US	

Total Est. Time: 1 hour, 35 minutes **Total Est. Distance:** 91.29 miles

From San Francisco

Maps/Directions

START	**1:**Start out going SOUTH on AIRPORT BLVD toward AIRPORT EXIT.	1.6 miles
SOUTH 5	**2:**Merge onto I-5 S toward SACRAMENTO / YUBA CITY.	8.9 miles
EXIT	**3:**Take the J STREET exit toward DOWNTOWN.	0.3 miles
	4:Stay STRAIGHT to go onto J ST.	0.9 miles
SOUTH 160	**5:**Turn RIGHT onto 15TH ST / CA-160 S.	0.2 miles
	6:Turn LEFT onto CAPITOL AVE.	<0.1 miles
END	**7:** End at **1501 Capitol Ave** Sacramento, CA 95814-5005, US	

Total Est. Time: 17 minutes **Total Est. Distance:** 12.19 miles

From Sacramento International Airport

Maps/Directions

	**1:**Take US-50 / CA-89 / EMERALD BAY RD. Continue to follow US-50 W.	98.6 miles
	**2:**Take the CA-160 / 16TH STREET exit.	0.2 miles
	**3:**Turn SLIGHT RIGHT onto 16TH ST / CA-160 N.	0.8 miles
	**4:**Turn LEFT onto CAPITOL AVE.	<0.1 miles
	**5:**Make a U-TURN at 15TH ST onto CAPITOL AVE.	<0.1 miles
	**6:** End at **1501 Capitol Ave** Sacramento, CA 95814-5005, US	

Total Est. Time: 2 hours, 2 minutes **Total Est. Distance:** 102.87 miles

From South Lake Tahoe